Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

July 28, 2026

[redacted]
ARDEN COURTS OF YARDLEY PA LLC
[redacted]

RE: ARDEN COURTS (YARDLEY)
493 STONY HILL ROAD
YARDLEY, PA, 19067
LICENSE/COC#: 12997

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/04/2026, 06/05/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ARDEN COURTS (YARDLEY)* **License #**: *12997* **License Expiration**: *04/30/2027*

Address: *493 STONY HILL ROAD, YARDLEY, PA 19067*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *ARDEN COURTS OF YARDLEY PA LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Complaint, Incident* **Exit Conference Date**: *06/05/2026*

Inspection Dates and Department Representative

06/04/2026 - On-Site: [redacted]

06/05/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *34*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *66* **Residents Served**: *34*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *34*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *34*

Have Physical Disability: *0*

Inspections / Reviews

06/04/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/20/2026*

07/22/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/28/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/24/2026*

Inspections / Reviews *(continued)*

07/28/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

Reviewer: [redacted] **Follow Up Type:** *Bypass Document Submission*

07/28/2026 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], at 5:00 pm, resident [redacted] was allegedly exposing their breast to resident [redacted] Resident [redacted] was allegedly touching the resident [redacted] in resident [redacted]s bedroom. This incident was observed by staff person A. However, the home did not have the copy of the Act 13 form required to be reported to the Area Agency on Aging.

Plan of Correction ***Accept [redacted] - 07/22/2026)***

The Executive Director reviewed the 02/02/2026 incident and obtained the record on 06/09/2026. A complete audit of abuse-reporting documentation was conducted to verify required reports were completed and retained. An Act 13 reporting file was established to maintain copies of all required reports and supporting documentation. Retraining was conducted for all leadership staff regarding abuse reporting requirements and document retention on 06/09/2026, and staff retraining was completed on 06/23/2026. On 06/09/2026, a weekly review of the Act 13 Reportable Incidents was conducted for 4 weeks. All incidents will be reviewed through QAPI monthly by the Executive Director or Designee

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented [redacted] - 07/28/2026)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at 5:00 pm, resident [redacted] was allegedly exposing their [redacted] to resident [redacted] Resident [redacted] was allegedly touching the resident's [redacted]. The home did not report this incident to the Department unti[redacted] at 4:00 pm.

On [redacted] at 10:15 am, resident [redacted] passed away. The home did not report this incident to the Department until [redacted] at 11:30 am.

Repeated Violation - [redacted], et al.

Plan of Correction ***Accept [redacted] 07/28/2026)***

The Executive Director reviewed all reported incidents to ensure timely submission on 06/09/2026. Retraining was conducted with leadership on 06/09/2026 to review timely submissions of reportable incidents, regulations 2600.16(c), and with staff on 06/23/2026. The Executive Director conducted weekly audits of reportable incidents over four weeks to assess the timeliness of submissions. All incidents will be reviewed through QAPI monthly by the Executive Director or Designee.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented[redacted] 07/28/2026)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident [redacted] was admitted to St. Mary Medical Center on [redacted]. According to the medical documentation the resident was admitted due to decreased intake and poor responsiveness. Resident [redacted] had prior admissions for periods of unresponsiveness which were generally resolved rather quickly, however this time the resident did not respond quickly. Resident [redacted] was treated for dehydration with fluids and had an adequate clinical response, becoming more responsive and alert. Resident [redacted] initial assessment and support plan dated [redacted] indicates the resident needs some physical assistance for eating and drinking. Resident [redacted] required encouragement and prompts to eat and drink. Resident [redacted] required direct care staff to offer fluids throughout the day and encouraged the resident to drink. Resident [redacted] most recent assessment and support plan dated [redacted] indicates the resident is independent with tasks related to dining without hands-on help or reminders from staff. Staff interviews revealed that resident [redacted] needed cueing to eat and drink and sometimes needed staff to feed [redacted] On [redacted], resident [redacted] was transported to the art studio at approximately 9:30 am-10:00 am by staff person A. Staff person A stated that when [redacted] transported the resident to the activity, [redacted] was "fine." Staff person B stated that the resident was in the art studio for about 30 minutes sleeping. Staff person B disclosed that the resident always sleeps during activities and sleeps in [redacted] w/c slouched to the side. Staff person B stated that [redacted] checked on the resident and [redacted] was not responding. Staff person B stated that they called for nursing staff to check on the resident. The progress note dated [redacted], states that resident [redacted] was in the activities room at 10:30 am. Resident [redacted] was unresponsive and drooling, the resident was assessed and staff person C attempted to arouse the resident by pulling ear and rubbing [redacted] chest the resident remained unresponsive, and had unlabored breathing, skin was pale in color. The resident was sent to the hospital via 911. Resident [redacted] was discharged on [redacted] from St. Mary's Medical Center and the diagnoses was stated as [redacted].

On [redacted], residents [redacted] and [redacted] were in the dining area in the dockside neighborhood when resident [redacted] asked resident [redacted] not to eat someone's food. Resident [redacted] physically punched resident [redacted] in the face, head, and body. Staff person D stated that they had to separate the residents twice because resident [redacted] made physical contact with resident [redacted] again. Resident [redacted] sustained a cut to [redacted] right upper forearm approximately 2.75cm x 4cm and an open bruise to the right approximately 1.75cm by 1.5cm. Resident [redacted] also sustained bruising on the bilateral arms and skin tear to [redacted] right hand and forearm. Staff persons D and E intervened and separated the residents. The Agent of the Department interviewed resident [redacted] Resident [redacted] disclosed feeling safe in the home and did not want to speak about the incident.

On [redacted], resident [redacted] was being escorted back to the Cloverdale neighborhood by staff person F at approximately 2:18 pm and passed by the art studio. Resident [redacted] was at the art studio and made a statement to resident [redacted] "Don't follow me." Staff person F explained that the resident was not following [redacted] and resident [redacted] repeated the statement. Progress note dated [redacted], states that resident [redacted] was struck in [redacted] left shoulder and chest. Staff people F and G immediately responded and separated the residents. Resident [redacted] denied pain and no injuries after the incident. On [redacted], resident [redacted] was assessed and a bluish bruise to the right of [redacted] nipple area and slight swelling was noted.

42b - Abuse (continued)

On [redacted] resident [redacted] was observed at the Berry Ridge neighborhood entrance raising [redacted] hand and swinging at resident [redacted] at 2:00 pm by physical therapy. Resident [redacted] was observed to be distressed and hunched over holding [redacted] chest. Resident [redacted] was assessed by staff person F and no injuries were noted. Resident [redacted] stated the reason for the incident was because resident [redacted] "irritated" [redacted] The Agent of the Department interviewed resident [redacted] and [redacted] was unable to recall the incident and disclosed feeling safe in the home.

On [redacted], resident [redacted] was transported to Jefferson Bucks Hospital due to [redacted] behavior and discharged with no new orders on [redacted]. On [redacted], resident [redacted] was transported to Lower Bucks Hospital Behavioral Unit and discharged on [redacted] to the home.

On [redacted] Resident [redacted] poured a pitcher filled with cold water on resident [redacted] 's head while the resident was sitting in the common area. Staff interview revealed that resident [redacted] was walking with staff to change [redacted] wet clothing and resident [redacted] hit the resident in [redacted] back. Staff person H disclosed that resident [redacted] responded, "Oh, that's cold" when resident [redacted] poured the water over [redacted] head. Staff person H intervened and resident [redacted] grabbed the staff person's wrist and bent [redacted] hands back. Staff person H stated that [redacted] told resident [redacted] "You are hurting me" and resident [redacted] let [redacted] go. Resident [redacted] was transported to Jefferson Bucks Hospital via 911. Resident [redacted] was assessed, and no injuries were noted. The Agent of the Department interviewed resident [redacted] and [redacted] was unable to recall the incident and disclosed feeling safe in the home.

Resident [redacted]s initial assessment and support plan dated [redacted] completed on the Department's support plan form, does not address agitation, irritability, aggression and hallucinations. The assessment and support plan addresses wandering, redirection, judgment and awareness. For Behavior, it stated that the "resident have frequent current issues and a history of frequent [redacted] or [redacted], verbally or physically improper. May require professional consultation or staff training."

The initial assessment and support plan dated [redacted], on the Department's support plan, indicates that agitation, irritability, aggression, and hallucinations are not a problem. The initial RASP states the resident requires 24-hour direct supervision.

Resident [redacted]s most recent assessment and support plan, dated [redacted] not completed on the Department's support plan form, does not address [redacted] and [redacted] The assessment and support plan addresses wandering, redirection, judgment and awareness. For Behavior, it stated that the "resident have frequent current issues and a history of frequent disruptive, aggressive or socially inappropriate behavior, verbally or physically improper. May require professional consultation or staff training."

Resident [redacted]s most recent assessment, dated [redacted] on the department's form following [redacted] readmission to the home from Lower Bucks Behavioral Health Unit, indicates that agitation, irritability, aggression, and hallucinations are not a problem. The most recent RASP states the residents require 24-hour direct supervision.

Resident [redacted] has had one-to-one private aid for 24 hours a day direct supervision since [redacted]

Repeated Violation-[redacted]

Plan of Correction ***Accept [redacted] - 07/28/2026)***

Resident[redacted] was discharged to a higher level of care on 01/08/206 and Resident [redacted] was discharged to a higher level

42b Abuse (continued)

of care on 06/03/2026.
An audit of residents with changes in condition and behavioral incidents is to be completed by 07/31/2026; if appropriate, the applicable residents' RASP's and Care Plans will be updated by the RSC. On 06/09/2026, a documented retraining was conducted on Regulation 2600.42b with leadership; on 06/11/2026, a documented retraining was conducted with RSC on resident behavior changes and a review of assessments; and on 06/23/2026, a documented retraining was conducted on Regulation 2600.42b with staff.
All behavioral incidents and changes in condition will be discussed during the morning leadership meetings x 5 days, then once weekly for 4 weeks; the meetings will be led and recorded by the Executive Director or Designee.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)

65e - 12 Hours Annual Training

4. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A received only 9 hours of annual training in training year 2025.
Direct care staff person F received only 10 hours of annual training in training year 2025.
Direct care staff person H received only 10.5 hours of annual training in training year 2025.
Direct care staff person I received only 10.5 hours of annual training in training year 2025.
Direct care staff person J received only 2.5 hours of annual training in training year 2025.
Direct care staff person K received only 10.5 hours of annual training in training year 2025.
Direct care staff person L received only 9.5 hours of annual training in training year 2025.

Plan of Correction ***Accept [redacted] - 07/28/2026)***

On 06/09/2026, the Executive Director conducted a documented retraining with all department managers on regulation 2600.65e. and with staff on 06/23/2026. An audit of applicable staff's 2025 training hours was completed on 06/12/2026 to identify staff who were not in compliance with the 2025 annual training hours requirement. The Executive Director is to initiate the 2026 annual training plan for all staff. The Executive Director or designee will conduct a monthly review through 08/20/2026 to maintain ongoing compliance and ensure that all direct care staff receive at least 12 hours of annual training related to their specific job duties.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

65f - Training Topics *(continued)*

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in Medication self-administration training during training year 2025.

Direct care staff person F did not receive training in Medication self-administration training, Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Care for residents with dementia and cognitive impairments. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. Safe management techniques during 2025 training year.

Direct care staff person I did not receive training in Medication self-administration and safe management techniques training during training year 2025.

Direct care staff person J did not receive training in Medication self-administration training, Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Care for residents with dementia and cognitive impairments. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. Safe management techniques during 2025 training year.

Direct care staff person K did not receive training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Care for residents with dementia and cognitive impairments. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. Safe management techniques during 2025 training year.

Direct care staff person L did not receive training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Care for residents with dementia and cognitive impairments. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. Safe management techniques during 2025 training year.

Direct care staff person M did not receive training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Care for residents with dementia and cognitive impairments. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. Safe management techniques during 2025 training year.

65f - Training Topics (continued)

Direct care staff person N did not receive training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. Care for residents with dementia and cognitive impairments. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. Safe management techniques during 2025 training year.

Repeated Violation - [redacted], et al.

Plan of Correction ***Accept[redacted] 07/28/2026)***

On 06/09/2026, the Executive Director conducted a retraining with all department managers on regulation 2600.65f. An audit of applicable staff's 2025 training hours was conducted on 06/12/2026 to identify staff who were not in compliance with the 2025 annual training hours requirement. The Executive Director is to initiate the 2026 annual training plan for all staff. The Executive Director or designee will conduct a monthly review through 08/20/2026 to maintain ongoing compliance and ensure that all direct care staff receive at least 12 hours of annual training related to their specific job duties.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)

65g - Annual Training Content

6. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in falls and accident prevention during training year 2025.

Staff person F did not receive training in falls and accident prevention during training year 2025.

Staff person I did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert. Emergency preparedness procedures and recognition and response to crises and emergency situations. Falls and accident prevention during training year 2025.

Staff person H did not receive training in falls and accident prevention during training year 2025.

Staff person I did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a

65g Annual Training Content (continued)

fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert. Emergency preparedness procedures and recognition and response to crises and emergency situations. Falls and accident prevention during training year 2025.

Staff person K did not receive training in falls and accident prevention during training year 2025.

Staff person L did not receive training in falls and accident prevention during training year 2025.

Staff person M did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert. Emergency preparedness procedures and recognition and response to crises and emergency situations. Falls and accident prevention during training year 2025.

Staff person N did not receive training in Resident rights and Falls and accident prevention during training year 2025.

Repeated Violation [redacted], et al.

Plan of Correction ***Accept ([redacted] - 07/28/2026)***

On 06/09/2026, the Executive Director conducted a retraining with all department managers on regulation 2600.65g. An audit of all staff's 2025 training hours was conducted on 06/12/2026 to identify staff who were not in compliance with the 2025 annual training topics. The Executive Director is to initiate the 2026 annual training plan for all staff. The Executive Director or designee will perform a monthly review through 08/20/2026 to maintain ongoing compliance and ensure all staff are trained on topics covered under regulation 2600.65g.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)

95 - Furniture and Equipment

7. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident room [redacted] did not have a toilet paper holder in the bathroom.

Plan of Correction ***Accept [redacted] 07/22/2026)***

A toilet paper holder was installed in room [redacted] during the inspection. On 06/08/2026, an audit was conducted in all occupied resident rooms to verify the presence of a toilet paper holder. Training was completed on 06/09/2026 with all department directors on Regulation 95, and on 06/23/2026, staff were trained on Regulation 95. The Executive Director or designee will conduct weekly audits for four weeks, beginning on 06/18/2026 and ending on 07/08/2026.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented [redacted] 07/28/2026)

141b1 - Annual Medical Evaluation

8. Requirements

141b1 - Annual Medical Evaluation *(continued)*

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted]s most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] 07/28/2026)***

Documented retraining was conducted on regulation 2600.141b1 with all leadership and on 06/23/2026 with staff. An audit will be conducted for all DME's to capture residents' DME's that are out of compliance; all will be reviewed by 07/31/2026. After the audit is completed, the community will implement a tracking file to ensure all residents' DME is completed annually or when there is a significant change. The DME tracker will be reviewed monthly in QAPI for dates coming due.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented ([redacted] - 07/28/2026)

183e - Storing Medications

9. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident [redacted] is prescribed [redacted] tablet take three tablets by mouth daily. On [redacted] at 2:07 pm, there was a tear on pill [redacted] that was covered with a pharmacy alerted sticker and the medication was still in the package.

Resident [redacted] is prescribed [redacted] take two tablets 10 mg by mouth daily at bedtime. On [redacted], at 2:16 pm, there was a tear on pills #3 and #10 and the medication still in the blister pack it was the package.

Repeated Violation - [redacted] et al.

Plan of Correction ***Accept [redacted] - 07/22/2026)***

On 06/05/2026, the Resident Services Supervisor removed and properly discarded the affected medications from blister packs with visible tears. On 06/08/2026, a documented audit was conducted of all medication carts; no additional instances of ripped or torn medication blister packs were found. On 06/09/2026, a documented education session was held for regulation 2600.183e with department managers. On 06/11/2026, a documented education session was conducted with nurses and med-techs to review blister pack inspection and the disposal of medication if holes are present. On 06/23/2026, a documented education session was held with staff on regulation 2600.18e. RSC or designee will perform weekly audits x 5 weeks through 07/16/2026 to maintain ongoing compliance by ensuring prescription medications are stored under proper conditions. Any deficiencies will be corrected immediately and reviewed internally for continuous improvement.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented [redacted] - 07/28/2026)

187d - Follow Prescriber's Orders

10. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] tablet scheduled for 4:00 pm. On multiple occasions their medication was administered late to include: [redacted] at 7:08 pm, [redacted] at 6:25 pm, and [redacted] at 5:55 pm.

Resident [redacted] is prescribed [redacted] cap scheduled for 6:00 am, 12:00 pm, and 10:00 pm. On multiple occasions this medication was administered late to include: [redacted] at 9:20 am, and [redacted] at 8:09 am.

Resident [redacted] is prescribed [redacted] tablet scheduled for 8:00 am and 8:00 pm. On multiple occasions this medication was administered late to include: [redacted] at 9:25 am, and [redacted] at 10:34 am.

Resident [redacted] is prescribed [redacted] scheduled for 8:00 am and 8:00 pm. On multiple occasions this medication was administered late to include: [redacted] at 9:50 am, and [redacted] at 10:12 am.

Resident [redacted] is prescribed [redacted] scheduled at 9:00 am daily. However, resident [redacted] was administered [redacted] on [redacted] at 11:20 am.

Resident [redacted] is prescribed [redacted] tablet take one tablet by mouth twice a daily at 8:00 am and 8:00 pm. However, resident [redacted] was administered [redacted] on [redacted] at 10:34 pm, on [redacted] at 10:27 am, and on [redacted] at 10:10 am.

Plan of Correction ***Accept [redacted] - 07/28/2026)***

RSC has requested statements from the nurses and medication technicians involved to determine whether the medications cited were administered as prescribed but documented after administration, resulting in delayed charting rather than delayed medication administration, the request for the statements was made on 07/20/2026.

Neighborhood spot monitoring will be conducted to assess any potential impact on other residents and to verify ongoing compliance with medication administration best practices, regarding.

A one to one retraining will be conducted with all nurses and med-techs to cover:
Regulation 2600.187(d) – Follow Prescriber's Orders
The Five Rights of Medication Administration
Timely medication administration
Timely and accurate documentation
Proper medication documentation practices

The Resident Services Coordinator, Executive Director, or designee will conduct weekly neighborhood medication administration audits and spot-monitoring for a period of four weeks to ensure sustained compliance, week one of the audits will begin 07/27/2027.

Licensee's Proposed Overall Completion Date: *08/09/2026*

187d Follow Prescriber's Orders *(continued)*

Implemented [redacted] - 07/28/2026)

234b Support Plan Needs Elements

11. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The home does not use the Department's support plan form. The home's support plan does not include all behavioral needs such as irritability, judgment, agitation, and hallucinations. The support plan for resident [redacted] dated [redacted], addresses wandering/redirection, judgement, awareness, and behaviors. The service plan indicates resident has a current or history of frequent disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper.

The home does not use the Department's support plan form. The home's support plan does not include all behavioral needs such as irritability, judgment, agitation, and hallucinations. The support plan for resident [redacted] dated [redacted], addresses wandering/redirection, judgement, awareness, and behavior. The service plan indicates occasional issues resident has a current or history of occasional disruptive, aggressive or socially inappropriate behavior verbally or physically improper.

However, the support plans do not document how the need will be met, frequency or the responsible party.

Plan of Correction ***Accept [redacted] - 07/28/2026)***

The community will conduct an audit of all support plans by 07/31/2026. All supports will be updated to meet regulatory compliance requirements to identify residents' physical, medical, social, cognitive, and safety needs. Documented training was completed with the Resident Services Coordinator on 06/11/2026 on the personalized elements of the support plan to address the residents' physical, medical, social, cognitive, and safety needs. Audit will be completed by 07/31/2026. All support plans will be reviewed annually or whenever there is a significant change to ensure the personalized elements of the residents' physical, medical, social, cognitive, and safety needs align. The support plans of 5 randomly selected residents will be reviewed weekly for 4 weeks by the community RSC or designee.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)

234d Support Plan Revision

12. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

The assessment for resident [redacted] dated [redacted] indicates the resident does not have a need for vision and has a

234d - Support Plan Revision (continued)

moderate hearing impairment. The resident's previous support plan dated [redacted], indicates the resident has a need for glasses and direct care staff to ensure resident's glasses are cleaned and placed with resident daily. The resident's support plan dated [redacted] states resident is hard of hearing and wears hearing aids. Direct care staff to ensure resident's hearing aids are placed in charger every night before and placed in the resident's ears each morning.

Staff interviews revealed that resident [redacted] utilized hearing aids and glasses daily. Staff interviews also revealed that the hearing aids and glasses were stored in the medication cart, and staff were responsible for ensuring the resident was wearing them daily.

The assessment for resident [redacted] dated [redacted], indicates that agitation, irritability, aggression, and hallucinations are not a problem. The most recent assessment for resident [redacted] dated [redacted], indicates that agitation, irritability, aggression, and hallucinations are not a problem. However, resident [redacted] has several physical altercations with residents and staff since [redacted] admission to the home on [redacted].

Plan of Correction ***Accept [redacted] - 07/28/2026)***

A documented retraining was conducted with the RSC on reviewing resident assessments. An audit will be conducted on all support plans to identify those out of compliance; all will be reviewed by 07/31/2026. After the audit is completed, the community will implement a tracking system to ensure that all residents' support plans are updated annually or when there is a significant change by the community RSC or designee. The support plan tracker will be reviewed monthly in QAPI for dates due and personalized elements of the plan that need updating.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)

236 - Staff Training

13. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had only 4.5 hours of training in dementia care during the 2025 training year.

Direct care staff person I who works in the Secure Dementia Care Unit (SDCU) had only 3 hours of training in dementia care during the 2025 training year.

Direct care staff person J, who works in the Secure Dementia Care Unit (SDCU) had only 1 hours of training in dementia care during the 2025 training year.

Direct care staff person K, who works in the Secure Dementia Care Unit (SDCU) had only 0 hours of training in dementia care during the 2025 training year.

Direct care staff person L, who works in the Secure Dementia Care Unit (SDCU) had only 0 hours of training in

236 - Staff Training (continued)

dementia care during the 2025 training year.

Direct care staff person N, who works in the Secure Dementia Care Unit (SDCU) had only 0 hours of training in dementia care during the 2025 training year.

Plan of Correction ***Accept [redacted] - 07/28/2026)***

On 06/09/2026, the Executive Director conducted a documented retraining with all department managers on regulation 2600.236 and with staff on 06/23/2026. An audit of applicable staff's 2025 training hours was completed on 06/12/2026 to identify staff who were not in compliance with the 2025 annual training hours requirement. The Executive Director is to initiate the 2026 annual training plan for all staff. To ensure ongoing compliance, the Executive Director or designee will conduct monthly reviews through 08/20/2026 and continue monthly monitoring thereafter to verify that each staff member is progressing toward, and ultimately completes, the required 6 hours of dementia-specific annual training.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)

251b - Record Entries Legible

14. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident [redacted] is prescribed [redacted] tablet take one tablet by mouth at bedtime as needed. On [redacted] and [redacted] the time of administration was written over and is not legible on the controlled substance log.

Plan of Correction ***Accept [redacted] - 07/28/2026)***

On 06/03/2026, Resident [redacted] was discharged to a higher level of care. An audit of all June 2026 controlled substance logs was conducted by the Executive Director on 07/20/2026 to assess the legibility and write-overs of administration times. A documented retraining of regulation 2600.251b was conducted with leadership on 06/09/2026 and staff on 06/23/2026. The RSC or designee will conduct weekly audits of the current controlled substances logs for 4 weeks to ensure continued compliance and correct any illegible entries.

Licensee's Proposed Overall Completion Date: *08/09/2026*

Implemented [redacted] - 07/28/2026)